

**State of New York
WORKERS' COMPENSATION BOARD
DISABILITY BENEFITS LAW**

**EMPLOYER'S APPLICATION TO HAVE ASSOCIATION, UNION OR
TRUSTEE PLAN ACCEPTED AS EMPLOYER'S PLAN**

An EMPLOYER participating in a Plan and Agreement of an association of employers or employees, union or trustees shall file this application in duplicate if the Plan is insured or in triplicate if the Plan is self-insured.

_____ Name of Employer (HEREIN CALLED THE EMPLOYER)			
_____ Name Under Which Business is Conducted			
_____ Number and Street	_____ City	_____ State	_____ Zip Code
_____ Federal Employer's Identification Number (If Sole Proprietor, Give Social Security No.)			
_____ Employer's U.I. Registration No. (If None, Give Reason)			

A. The EMPLOYER requests acceptance of this PLAN and AGREEMENT identified by W.C.B. Plan Number _____
of _____ Association, Union or Trustees as the EMPLOYER'S Plan.

1. The Plan covers the EMPLOYER'S employees as follows:

- All employees eligible for benefits under the New York Disability Benefits Law.
- All employees eligible for benefits under the Disability Benefits Law except those classes of employees eligible to receive Benefits under another policy or plan accepted by the Chair.
- Only the following class or classes of employees: _____

2. Number of EMPLOYER'S employees covered under this Plan _____

3. The EMPLOYER became (will become) a Participating Employer in the Plan on _____ (Date)

B. The EMPLOYER agrees:

- 1. That all eligible employees will be provided Benefits either by the Plan or in one or more of the ways specified in Sec. 211 of the Disability Benefits Law.
- 2. That any excess of the aggregate contributions of employees over the cost of providing Benefits and any uncommitted balance of employee contributions remaining at the termination of this Plan shall be distributed or applied for the sole benefit of employees or otherwise be applied or disposed of pursuant to Sec. 210, subdivision 4, and Sec. 216 of the Disability Benefits Law.
- 3. That the Plan Benefits will be continued until the Employer has filed written notice with the Chair of the termination of the Plan.

Employer

Date Signed _____ By _____
Signature of Owner, Partner or Authorized Officer

Telephone No.: _____ Title _____

CERTIFICATION BY ASSOCIATION, UNION OR TRUSTEES

STATE OF NEW YORK

COUNTY OF.....

.....being duly sworn, deposes and says:
Name of Authorized Official

That he or she is the..... of the.....
Name of Association, Union or Trustees

and is duly authorized to execute this affidavit of certification on behalf of said Association, Union or Trustees.

That EMPLOYER became (will become) a participating Employer in the Plan on.....that, during the term of the Plan as accepted by the Chairman of the Workers' Compensation Board, the EMPLOYER'S participation will continue to be effective until ten days after a written notice of termination is served on the EMPLOYER and filed with the Chairman of the Workers' Compensation Board by or on behalf of the Association, Union or Trustees.

That the employees specified on this form by the EMPLOYER will be provided benefits under the accepted Plan of this Association, Union or Trustees.

.....
Signature of Authorized Official

Sworn to before me this

.....day of.....

.....
Signature of Notary Public

INSTRUCTIONS

1. Each completed form is to be executed by the EMPLOYER, certified by the Association, Union or Trustees, and sworn to before a notary public before filing.
2. Mail the form for filing, in duplicate, to:

<p>WORKERS' COMPENSATION BOARD DISABILITY BENEFITS BUREAU PLANS ACCEPTANCE UNIT 100 BROADWAY-MENANDS ALBANY, NY. 12241-0005</p>
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THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.